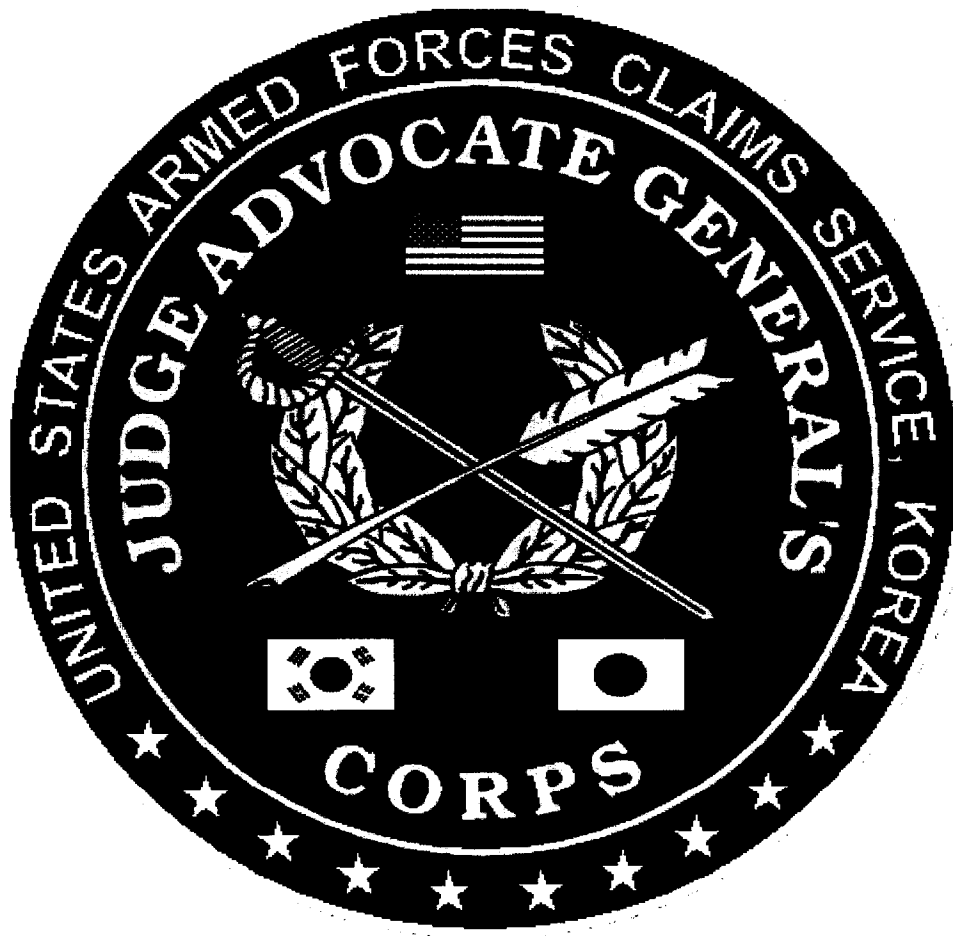


UNITED STATES ARMED FORCES



CLAIMS SERVICE-KOREA



DEPARTMENT OF THE ARMY
UNITED STATES ARMED FORCES CLAIMS SERVICE, KOREA
UNIT #15311
APO AP 96205-5311

REPLY TO
ATTENTION OF:

FKJA-CSK (27-20a)

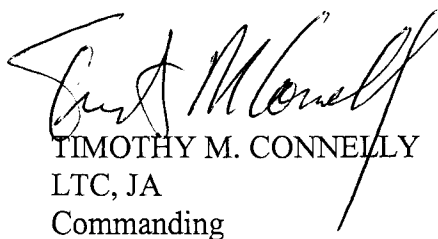
1 September 2004

MEMORANDUM FOR CLAIMANTS AGAINST THE UNITED STATES GOVERNMENT

SUBJECT: Procedures for Filing Tort Claims

1. Welcome to the U.S. Armed Forces Claims Service – Korea. Enclosed are instructions and forms explaining how to file a tort claim against the United States for wrongful death, personal injury, and property damage.
2. It is unfortunate that you have suffered a loss or injury. Our goal is to investigate and fairly settle your claim as quickly as possible. Please understand, however, that Congress and the Department of the Army have placed restrictions on our authority to pay claims of this nature. To ensure that we can pay you the full amount of money to which you are entitled under the law, it is important that you read and carefully follow the enclosed instructions, that you carefully complete all applicable claims forms, and that you submit all the required documentation to substantiate your claim.
3. If your work schedule does not permit a personal visit to our office, please call and request an appointment with a claims adjudicator at your place of work.
4. A claims survey form is attached to this letter. We are genuinely interested in your comments regarding our service to you and welcome any suggestions for improvements. Please return this form at the time you file your claim or fold it in half and mail it postage-free through the MPS. If you have additional comments at a later time, extra survey forms are available at the Claims Office.
5. The Claims Office will be open Monday through Wednesday and Friday from 0800 – 1600 hours. Our office is open Thursday mornings **for turn-in of DD Forms 1840 and 1840R only** and closed Thursday afternoons for training. We are closed every day from 1200 – 1300. Please contact our office to make an appointment to come in to file your claim. If you need assistance at any stage in the claims process, please do not hesitate to contact us at 738-8111/8219/8242/8294.

Encls
as


TIMOTHY M. CONNELLY
LTC, JA
Commanding

TORT CLAIM CHECKLIST

1. Please bring the original and legible copies of the indicated forms to aid us in processing your claim quickly and thoroughly. Your claim must include the following and be completed in black ink:

- ☐ a. **SF 95** (enclosed)
- ☐ b. **DD Form 1844** (enclosed)
- ☐ c. **Written Repair Estimates**- A partial list of repair firms is enclosed. Normally only one estimate is required.
- ☐ d. **MP Blotter/MP Report**- If one was prepared.
- ☐ e. **Replacement Costs**- Before a replacement cost can be given, an estimate of repair is needed to show that the item is not repairable. If the item is repairable, then no replacement cost will be given.
- ☐ f. **Vehicle Registration** (if applicable)
- ☐ g. **Valid Insurance Policy** (if applicable)
- ☐ h. **Driver's License** (if applicable)
- ☐ i. **Any other documents pertaining to the incident**
- ☐ j. **Electronic Fund Transfer Worksheet**- (enclosed) If you are not Active Duty Army you will need to complete this form. If entitled to payment, it will be made by direct deposit into your bank account. Completely fill out this form. Ensure the correct routing and account numbers are on the form. If they are not, then it will delay your payment.
- ☐ k. **Power of Attorney**- You must have this if you are filing for your sponsor, spouse, or someone else.

2. You have two years from the date of the incident to file a claim.

3. If you desire copies of any forms or documents pertaining to your claim, you should make these copies prior to coming to the Claims Office. You must turn in all original documents to the Claims Office. If you need assistance, feel free to come by our office during normal office hours or call to speak to one of our representatives.

CLAIM FOR DAMAGE, INJURY, OR DEATH		INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.		FORM APPROVED OMB NO. 1105-0008	
1. Submit To Appropriate Federal Agency: U.S. Armed Forces Claims Service-Korea Unit # 15311 APO AP 96205-5311			2. Name, Address of claimant and claimant's personal representative, if any. <i>(See instructions on reverse.) (Number, street, city, State and Zip Code)</i> MSG Jesse D. James 123-45-6789 PSC 303 BOX 02 APO AP 96204 Tel. 738-5555		
3. TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> MILITARY <input type="checkbox"/> CIVILIAN	4. DATE OF BIRTH 12 Dec 81	5. MARITAL STATUS M	6. DATE AND DAY OF ACCIDENT 24 Feb 04, Tuesday	7. TIME (A.M. OR P.M.) 1002 am	
8. Basis of Claim <i>(State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof) (Use additional pages if necessary.)</i> DESCRIBE ALL KNOWN DETAILS RELATING TO THE INCIDENT FOR WHICH YOU ARE FILING YOUR CLAIM.					
9. PROPERTY DAMAGE					
NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT <i>(Number, street, city, State, and Zip Code)</i> IF APPLICABLE					
BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. <i>(See instructions on reverse side.)</i> FILL OUT AS DETAILED AS POSSIBLE.					
10. PERSONAL INJURY/WRONGFUL DEATH					
STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT. IF APPLICABLE					
11. WITNESSES					
NAME		ADDRESS <i>(Number, street, city, State, and Zip Code)</i>			
IF APPLICABLE		IF APPLICABLE			
12. (See instructions on reverse) AMOUNT OF CLAIM (in dollars)					
12a. PROPERTY DAMAGE \$850	12b. PERSONAL INJURY \$60	12c. WRONGFUL DEATH	12d. TOTAL <i>(Failure to specify may cause forfeiture of your rights.)</i> \$910		
I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM					
13a. SIGNATURE OF CLAIMANT <i>(See instructions on reverse side.)</i> YOU SIGN HERE			13b. Phone number of signatory CURRENT TELEPHONE #	14. DATE OF CLAIM DATE SUBMITTED	
CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM The claimant shall forfeit and pay to the United States the sum of \$2,000, plus double the amount of damages sustained by the United States. <i>(See 31 U.S.C. 3729.)</i>			CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS Fine of not more than \$10,000 or imprisonment for not more than 5 years or both. <i>(See 18 U.S.C. 287, 1001.)</i>		

Previous editions not usable.

STANDARD FORM 95 (Rev. 7-85)
 PRESCRIBED BY DEPT. OF JUSTICE
 28 CFR 14.2
 USAPPC V1.00

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. **Authority:** The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. **Principal Purpose:** The information requested is to be used in evaluating claims.
 C. **Routine Use:** See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.
 D. **Effect of Failure to Respond:** Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

INSTRUCTIONS

Complete all items - Insert the word **NONE** where applicable

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A **SUM CERTAIN** FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN **TWO YEARS** AFTER THE CLAIM ACCRUES.

Any instructions or information necessary in the preparation of your claim will be furnished, upon request, by the office indicated in item #1 on the reverse side. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplemental regulations also. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with said claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file claim for both personal injury and property damage, claim for both must be shown in item 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) Failure to completely execute this form or to supply the requested material within two years from the date the allegations accrued may render your claim "invalid". A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

Failure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes. If yes, give name and address of insurance company (Number, street, city, State, and Zip Code) and policy number ☐ No

16. Have you filed claim on your insurance carrier in this instance, and if so, is it full coverage or deductible?

IF APPLICABLE

17. If deductible, state amount

18. If claim has been filed with your carrier, what action has your insurer taken or proposes to take with reference to your claim? (It is necessary that you ascertain these facts)

IF APPLICABLE

19. Do you carry public liability and property damage insurance? ☐ Yes. If yes, give name and address of insurance carrier (Number, street, city, State, and Zip Code) ☐ No

CLAIM FOR DAMAGE, INJURY, OR DEATH		INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of the form. Use additional sheet(s) if necessary. See reverse side for additional instructions.		FORM APPROVED OMB NO. 1105-0008	
1. Submit To Appropriate Federal Agency:			2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, street, city, State and Zip Code)		
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7. TIME (A.M. or P.M.)					
8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof) (Use additional pages if necessary.)					
9. PROPERTY DAMAGE					
NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, street, city, State, and Zip Code)					
BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)					
10. PERSONAL INJURY/WRONGFUL DEATH					
STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.					
11. WITNESSES					
NAME		ADDRESS (Number, street, city, State, and Zip Code)			
12. (See instructions on reverse) AMOUNT OF CLAIM (In dollars)					
12a. PROPERTY DAMAGE		12b. PERSONAL INJURY		12c. WRONGFUL DEATH	
				12d. TOTAL (Failure to specify may cause forfeiture of your rights.)	
I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.					
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				14. DATE OF CLAIM	
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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden,

to Director, Torts Branch
Civil Division
U.S. Department of Justice
Washington, DC 20530

and to the
Office of Management and Budget
Paperwork Reduction Project (1105-0008)
Washington, DC 20503

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17. If deductible, state amount

18. If claim has been filed with your carrier, what action has your insurer taken or proposes to take with reference to your claim? (It is necessary that you ascertain these facts)

19. Do you carry public liability and property damage insurance? ☐ Yes, If yes, give name and address of insurance company (Number, street, city, State, and Zip Code) ☐ No

ELECTRONIC FUND TRANSFER WORKSHEET

PAYEE INFORMATION

NAME (Last, First, Middle Initial): _____

Mailing Address: _____

Social Security Number: _____

Telephone Number (DSN or COMM): _____

FINANCIAL INSTITUTION INFORMATION

NAME: _____

Address: _____

9-digit Routing Number: _____

Depositor Account Number: _____

Type of Account: ☐ Checking ☐ Savings

Claimant Signature: _____

PRIVACY ACT STATEMENT

The following information is provided to comply with the Privacy Act of 1974 (P. L. 93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 C.F.R. 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's or individual's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.

****NOTE:** This is the only means available to receive your claims settlement, unless your situation provides for an emergency payment, which will be determined by the NCOIC, Personnel Property Claims or the Claims Judge Advocate.

PARTIAL LISTING OF REPAIR SHOPS

The Claims Service has prepared this as a service to USFK Personnel. It is intended as a partial listing only. Listing of a firm does not constitute an endorsement of its products or services by the U.S. Government or the Claims Service. Exclusion of a firm from this list does not imply that such a firm is unreliable or should not be used. All phone numbers listed are off-post Korean civilian numbers unless otherwise noted. If you find any errors in the listings below or if you are aware of any additional firms performing any of the services listed, please let our office know.

AUTOMOTIVE REPAIR

AUTO Craft Shop
TEL: DSN 738-5315/ 5042

Dunlop Body/Repair
TEL: 794-4345

Youngjin Auto Glass
(Windshield/Glass only)
TEL: 793-1990/795-6144

BICYCLE REPAIR

Do All Interior Co.
TEL: 797-3213/798-1237

CARPET/SOFA/ CURTAINS/UPHOLSTERY

Do All Interior Co.
TEL: 797-3213/798-1237

COMPUTERS/TYPEWRITERS/ OFFICE MACHINE

Chin Han C & C (Yongsan Gallery)
TEL: DSN 723-4030

Jonny Computer
TEL: 790-8839

Do All Interior Co.
TEL: 797-3213/798-1237

FUR/LEATHER/SUEDE

Mimi Dry-cleaning
TEL: 793-1879/790-9843

FURNITURE REPAIR

KOREANA FOLKCRAFT CO.
(Mr. Symon Jeonn)
TEL. 790-6641
CELL. 011-722-6642

Do All Interior Co.
TEL: 797-3213/798-1237

GRANDFATHER CLOCKS

Do All Interior Co.
TEL: 797-3213/798-1237

MUSICAL INSTRUMENTS

Do All Interior Co.
TEL: 797-3213/798-1237

REFRIGERATOR/AIR CONDITIONER

AAFES Concession Repair
TEL: DSN 723-4117

Do All Interior Co.
TEL: 797-3213/798-1237

TV/RADIO/STEREO/CAMCORDER REPAIR

AAFES Electronic Repair Shop
TEL: DSN 738-5274

Do All Interior Co.
TEL: 797-3213/798-1237

CLAIMS SURVEY

Please answer the questions below and furnish comments to assist us in providing better service to our customers. After completing the survey, place it in either the survey box located in the Claims Office or fold it in half and mail it postage free through the Military Postal System.

1. What was the name of the person who assisted you during your visit to our office?

2. Is there anything you would like this person to have done differently?

3. How would you rate the service you were provided during your visit (Check One)

_____Excellent _____Good _____Fair _____Poor

4. Did the instructions in the claims packet adequately explain how to prepare your claim forms?

____ Yes ____ No If not, what was it that was unclear to you? How could it be improved?

5. Were you given a satisfactory explanation concerning the methods the Claims Office used to compute your claim settlement?

____Yes ____No If not, what other information should we have provided?

OPTIONAL: _____

Your Name

Work Number

Date _____